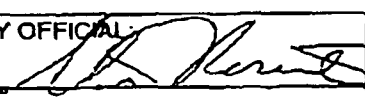


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>03-021</u>	2. STATE: CA
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		4. PROPOSED EFFECTIVE DATE August <u>1</u> , 2003	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:		7. FEDERAL BUDGET IMPACT: a. FFY 2003 \$ 0 b. FFY 2004 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Page 12		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D Page 12	
10. SUBJECT OF AMENDMENT: Removal of Discretionary Language of Add-Ons			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor's office does not wish to review State Plan Amendments			
12. SIGNATURE OF STATE AGENCY OFFICIAL: Stan Rosenstein 		16. RETURN TO: Department of Health Services Attn: State Plan Coordinator 714 P Street, Room 1640 Sacramento, CA 95814	
13. TYPED NAME: Deputy Director		17. DATE RECEIVED:	
14. TITLE:		18. DATE APPROVED:	
15. DATE SUBMITTED: <u>9/30/03</u>		19. EFFECTIVE DATE OF APPROVED MATERIAL: <u>January 1, 2004</u>	
20. TYPED NAME: William Lasowski		21. TITLE: Acting Deputy Director CMSO	
23. REMARKS: Per v m k change block # 4			

overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

- B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting requirements of state or federal laws or regulations including the costs of special programs.

- C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add on" may be used to reflect other extraordinary costs experienced by intermediate care facilities for the developmentally disabled (including habilitative and nursing facilities for the developmentally disabled). Add ons for extraordinary costs shall not be considered for other categories of long term care providers. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to HCFA by December 31st of the rate year, as a part of Supplement 1.

- D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.